National Institutes of Health
Warren Grant Magnuson Clinical Center
Nursing and Patient Care Services

Standard of Practice: Transfer of a Patient to the Operating Room

I. ASSESSMENT

A. Review Medical Record
1. Medical Record review will begin as soon as operative procedure has been scheduled
2. Review physician orders for:
   a. NPO status
   b. Preoperative medications (sedatives, antibiotics, etc.)
   c. Status of routine medications
      - IDDM and NIDDM medications
      - Cytotoxic agents
      - Investigational agents
      - Others as ordered
   d. Laboratory work
   e. Intravenous hydration
   f. Sequential Compression Device and/or TEDS
3. Consents are signed, dated, and witnessed prior to administration of sedatives/anxiolytics
   a. Request for Administration of Anesthesia and for Performance of Operation and Other Procedures
   b. Protocol consent
   c. Consent for Transfusion of Blood Components, if applicable
   d. Sterilization consent, if applicable
4. Preoperative diagnostic study reports are available on chart
   a. Lab work, as ordered by prescriber
   b. Type and Cross Match within 72 hours, if applicable
   c. Chest X-Ray within 72 hours or, as ordered by prescriber
5. EKG report or tracing
   a. Patients over 40 years of age EKG within 1 month
   b. Patients with a history of cardiac disease EKG within 1 month
6. Labels on chart
   a. Addressograph labels
   b. Allergy labels, if appropriate

c. Isolation labels, if appropriate
d. Radioactive labels, if appropriate

B. Patient Assessment
1. Hospital identification bracelet is accurate and legible
2. Typenex® band (if applicable) is current and legible
3. Allergy band (if applicable) is current and legible
4. Surgical site is marked, when appropriate, prior to the administration of sedatives/anxiolytics.
5. Attire
a. Undergarments have been removed
b. Wearing non wrap-around hospital gown
c. All jewelry (including religious and body piercing jewelry) has been removed and secured. Ring cutter (if necessary) is available in CHS
d. Hair ornaments, wigs, and/or hair pieces have been removed
e. Make-up and nail polish have been removed; consult with anesthesia to determine if acrylic nails should be removed
f. Dentures (partial and full plates), prostheses, hearing aids, contact lens, and glasses have been removed and secured
g. Menstruating females will have tampons removed and peri pads in place without belt
h. Patients with ostomy appliances will have extra pouch on chart
6. Patient/Family learning needs
a. Operative procedure
b. Preoperative preparation (diagnostic tests, medications, NPO status, etc.)
c. Recovery phase (ICU vs. PACU, OR and/or unit tours, length of recovery)
d. Postoperative (lifestyle changes, anticipated equipment and/or appliances)

II. INTERVENTIONS
A. Patient Preparation
1. Initiate patient/family teaching as soon as operative procedure has been scheduled:
a. Operative procedure
b. Preoperative preparation (diagnostic tests, medications, NPO status, etc.)
c. Recovery phase (ICU vs. PACU, OR and/or unit tours, length of recovery)
d. Post-operative (lifestyle changes, anticipated equipment and/or appliances)
2. Prior to administration of preoperative sedatives:
a. The surgical/invasive procedure site has been marked, if appropriate.
b. Measure vital signs and obtain weight
c. Assist patient to void
d. Ensure consents have been signed and witnessed
3. Administer ordered preoperative medications

a. If IV access required for pre-medications, adult patients will have an 18 g angiocath placed by RN; pediatric patients will have the largest gauge angiocath possible placed based on age and size.
b. Medications (antibiotics, sedatives, etc.) ordered as "ON-CALL" will be given when the OR staff call nursing unit for the patient; if administering an agent known to induce minimal sedation (anxiolysis), monitor oxygen saturation continuously (per M92-9: Administration of Sedation)
c. Medications (antibiotics, sedatives, etc.) ordered as "MORNING OF SURGERY" will be given at 7:00 a.m.
d. Medications ordered for "TO FOLLOW" cases will be placed on unit chart unless otherwise notified by OR staff

B. Chart preparation morning of operative procedure
1. Gather medical record, and unit chart
2. Attach addressograph plate to medical record
3. If patient has ostomy appliance, include clean ostomy pouch on chart
4. Print and attach Interim Summary ("12 Midnight to Now") to chart after completion of documentation
5. Include "on-call" medications with unit chart
6. Completed OR Checklist on front of unit chart
7. Pediatric Emergency Drug Sheet on front of unit chart

C. Transport patient to OR
1. All patients scheduled for 8:00 a.m. will be ready for transport by 7:00 a.m.
2. Patients going to the OR will be accompanied OR Health Technician. RN may be requested to accompany patient to the OR if patient's clinical status requires monitoring.
3. Intravenous infusions will be monitored and maintained by nursing unit personnel; infusion pumps will be removed in the OR receiving area and returned to nursing unit personnel
4. Pediatric patients will be transported to the OR in a crib or stretcher as provided by the OR; parent may accompany child
5. Prepare patient's room for return from PACU
a. IV equipment
b. Clean bed linen
c. Bed in high horizontal position

III. DOCUMENTATION

A. OR Checklist
1. Initiate as soon as operative procedure has been scheduled and complete immediately prior to transport from the PCU.
2. All RNs documenting on the OR Checklist will initial in the appropriate area and sign, date/time document

B. MIS
1. Vital Signs (BP, TPR, oxygen saturation), height and weight
2. Current assessment
3. "To the OR" note (Nursing Master Guide / To the OR / OR Transfer Note and To the OR Surg

IV. REFERENCES

A. Association of Operating Room Nurses (2001). Standards, Recommended Practices and Guidelines, Denver: Association of Operating Room Nurses, Inc.
B. Fairchild, S. (1993). Perioperative Nursing, p. 286-297 Boston: Jones and Bartlett Publishers
C. Meeker, M. and Rothrock, J. (1995). Alexander's Care of the Patient in Surgery, St. Louis: Mosby Year Book, Inc.
D. Medical Administrative Manual Series
    1. M77-2: Informed Consent
    2. M92-2: Policy of Voluntary Sterilization of Clinical Center Patients
    3. M93-7: Patient Identification and Bracelet
    4. M92-9: Administration of Sedation
    5. M03-2: Correct Site Identification for Surgical/Invasive Procedures

Approved:

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